DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 8/24/13

PRINTED: 07/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445458	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS HEALTH CARE CENTER	1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 1-story Type V(111), unprotected, Combustible construction with a complete automatic sprinkler system. K6 PLAN APPROVAL: 1981 K7 SURVEY UNDER: 2000 EXISTING K8 84-bed SNF/NF	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure all magnetically locked doors released upon fire alarm activation. Findings include: Observation and interview with the Maintenance Director, on July 8, 2013 at 1:55 p.m. confirmed one (1) of eight (8) magnetically locked doors, by room #1, failed to release when the fire alarm activated. The delayed egress functioned properly and all staff interviewed knew the code to unlock the door. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 8, 2013.	K 038	K 038 1. Magnetically locked door by room #1 was repaired by Maintenance Director on July 8, 2013 and released correctly when activated by fire alarm. 2. On July 8, 2013 Maintenance Director audited all other magnetically locked doors to ensure magnetically lock doors release when the fire alarm is activated. 3. Administrator inserviced Maintenance Director on July 8, 2013 to ensure all magnetically locked doors release during fire drills. 4. An audit conducted by Maintenance Director, Staff Development Coordinator or Shift Supervisor on all magnetically locked doors for automatic release during fire drills will be completed weekly for one month and then monthly for two months and/or until 100% compliance. The results of the audits will be presented by the Maintenance Director to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance	K 052	K 052 1. On July 10, 2013 Maintenance Director initiated contract with East TN Fire to rework the fire alarm strobes per regulation requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Lora Goodman — Administrator — 7/22/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 052	Continued From page 1 with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire alarm strobes were synchronized where more than two were in the field of view. The findings include: Observation and interview with the Maintenance Director, on July 8, 2013 at 2:10 p.m., confirmed fire alarm strobes in the facility did not flash in synchronization. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 8, 2013.	K 052	2. East TN Fire Alarm will audit all fire alarm strobes to insure they are synchronized when rework is complete. 3. On July 8, 2013 Administrator inserviced Maintenance Director on fire alarm strobe light synchronization. Maintenance Director will include fire alarm strobe synchronization in PM schedule check. 4. An audit by Maintenance Director of strobe light synchronization will be conducted upon completion and monthly for three months and/or until 100% compliance. The results of the audits will be presented by the Maintenance Director to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.	K 066	K 066 1. On July 7, 2013 Maintenance Director removed noncombustible trashcan with self-closing from designated smoking area. On July 18, 2013 Maintenance Director placed metal container with self-closing cover in designated smoking area. 2. Facility has only one designated smoking area; no other areas involved.	

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K 066	Continued From page 2 (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined smoking areas were not provided with metal containers with self-closing cover devices. The findings include: Observation and interview with the Maintenance Director, on July 8, 2013 at 9:50 a.m. confirmed the smoking area had a plastic trash receptacle. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 8, 2013.	K 066	3. On July 8, 2013 Maintenance Director was inserviced by Administrator to ensure metal container with self-closing cover is placed at designated smoking area. 4. An audit by Maintenance Director will be conducted to ensure metal container with self-closing lid is present in smoking area weekly for one month and then monthly for three months and/or until 100% compliance. The results of the audits will be presented by the Maintenance Director to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	K 067 1. On July 18, 2013 Maintenance Director obtained fire damper maintenance proposals from contractors to complete fire damper inspection. 2. Contractor will audit and conduct maintenance inspection on all fire dampers to begin August 1, 2013.	

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K 067	Continued From page 3 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined fire dampers were not maintained at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. The findings include: Record review and interview with the Maintenance Director on July 8, 2013 at 10:00 p.m. confirmed the facility failed to perform the 4-year required maintenance to fire dampers. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 8, 2013.	K 067	3. On July 8, 2013 Administrator inserviced Maintenance Director on fire damper inspection. Maintenance Director will verify fire damper maintenance is completed and will include on PM schedule. 4. An audit to ensure fire damper maintenance inspection will be conducted by Maintenance Director. The results of the audit will be presented by the Maintenance Director to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3, 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the commercial cooking stove and deep fryer were not separated by at least 16 inches. The findings include: Observation and interview with the Maintenance Director, on July 8, 2013 at 8:45 a.m. confirmed the deep fryer and gas stovetop were 9-inches apart. This finding was verified by the Maintenance Supervisor and acknowledged by the	K 069	K 069 1. On July 12, 2013 maintenance director mounted an 8" stainless steel divider plate on left side of gas cooking stove separating cooking stove from deep fryer. 2. Facility kitchen only has one cooking stove and one deep fryer. No other divider plates are needed. 3. On July 9, 2013 maintenance director was inserviced by administrator on mounting an 8" stainless steel divider plate on left side of gas cooking stove separating cooking stove from deep fryer. 4. An audit to ensure 8" stainless steel divider plate is properly mounted and located on cooking stove will be conducted monthly for three months and/or until 100% compliance. The results of the audits will	

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K 069	Continued From page 4 Administrator during the exit conference on July 8, 2013.	K 069	be presented by the Maintenance Director to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the emergency generator and transfer switch locations in accordance with NFPA 99 and NFPA 110. The findings include: 1. Observation and interview with the Maintenance Director, on July 8, 2013 at 10:40 a.m. confirmed the emergency generator transfer switch location was not provided with battery-powered emergency lighting. 2. Based on record review and interview, it was determined the facility failed to perform an annual 2-hour load bank test on their emergency generator. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on July 8, 2013.	K 144	K 144 1. (a) On July 9, 2013 Maintenance Director installed emergency battery-powered emergency lighting in the emergency generator transfer switch mechanical room. (b) Facility Maintenance Director scheduled an annual 2-hour load test to be performed on the emergency generator on July 24, 2013. 2. (a) Facility only has one mechanical room that houses an emergency generator transfer switch where an emergency battery-power emergency light is required. No other mechanical rooms were affected. (b) On July 24, 2013 Shofner Mechanical conducted a 2-hour load test on the emergency generator. Facility only has one emergency generator.	